U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 07 May 2004

CASE NO.: 2003-BLA-05089

In the Matter of:

EDWARD MERRILL
Claimant,

v.

MANALAPAN MINING CO.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest.

Appearances:

Edmond Collett , Esq.
For the Claimant

Greg Little, Esq.
For the Employer

Before: MOLLIE W. NEAL
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits filed pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1972 and the Black Lung Benefits Reform Act of 1977, 30 U.S.C. 901 et seq. (the Act) and the regulations issued thereunder and found at Title 20, Code of Federal Regulations (C.F.R.)

Benefits under the Act are awardable to persons who are totally disabled within the meaning of the Act due to pneumoconiosis. Benefits are also awardable to the survivors of persons whose death was caused by pneumoconiosis, and for claims filed prior to January 1, 1982, to the survivors of persons who were totally disabled from pneumoconiosis at the time of their deaths. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment. It is commonly known as black lung.

The Claimant, Edward Merrill, filed his claim on February 5, 2001. (DX 2). His application was initially denied by the District Director in a Proposed Decision and Order dated July 9, 2002. (DX 26). The Claimant filed a timely request for a hearing, and on October 24, 2002, this matter was referred to the Office of Administrative Law Judges. (DX 30

A formal hearing was held before me in Harlan, Kentucky on September 10, 2003. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and the regulations. Director's exhibits 1-31; Claimant's exhibits 1-4; and Employer's Exhibits 1-15 were admitted. (Tr. 6, 9, 15, 16).[1] The Claimant was provided the opportunity, post-hearing, to submit a re-reading of the April 3, 2001 chest x-ray, while Employer was provided the opportunity to submit, post-hearing, a re-reading of the July 24, 2002 chest x-ray. (Tr. 18). By cover letter dated September 11, 2003, Employer has submitted a reading of the July 24, 2002 x-ray by Dr. Wheeler. That evidence has already been submitted and is part of the record as Employer's exhibit 12. Therefore, the current submission is duplicative and will not be admitted herein. The parties were provided the opportunity to submit post-hearing briefs, and same was submitted by Employer. The record is now closed.

The findings of fact and conclusions of law which follow are based upon my thorough analysis and review of the entire record, arguments of the parties, and applicable statutes, regulations, and case law

ISSUES

The issues in this case are: (1) whether the Claimant has pneumoconiosis as defined by the Act and the Regulations; (2) whether the Claimant's pneumoconiosis arose out of coal mine employment; (3) whether the Claimant is totally disabled; and (4) whether the Claimant's disability is due to pneumoconiosis. (DX 30, Tr. 18-19).

Employer withdrew the issues relating to the timely filing of the claim, whether the claimant was miner within the meaning of the Act, and whether Manalapan was the coal mine employer responsible for the payment of benefits in this claim. (Tr. 18-19)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Coal Mine Employment/Responsible Operator

The Employer stipulated to twenty-three years of coal mine employment. (Tr. 18), and the Social Security Administration's Itemized Statement of Earnings (DX 8), the W-2 statements and other verification of coal mine employment (DX 3-4, 7-8), and Claimant's

[1] The following references will be used herein: "CX" designates Claimant's exhibits; "DX" designates Director's exhibits; "EX" designates Employer's exhibits; and "Tr." designates the transcript of the hearing held on September 10, 2003.

testimony (Tr. 23-24) supports a finding that Claimant worked as a coal miner for twenty-three years. He was last employed as a coal miner by Manaplapan in the state of Kentucky, as a superintendent. He last worked as a coal miner in November of 2000, when he left the employ of Manalapan due to illness (Tr. 24, DX 6, DX 7).

Adjudicatory Rules

Because this claim was filed in 2001, it is governed by the regulations at 20 C.F.R. Part 718. Under Part 718, the Claimant must prove by a preponderance of the evidence that: (1) he suffers from pneumoconiosis; (2) such pneumoconiosis arises out of coal mine employment; (3) he is totally disabled; and (4) his total disability is caused by pneumoconiosis. *Gee v. W. G. Moore & Sons*, 9 BLR 1-4(1986)(en banc); *Baugmartnder v. Director, OWCP*, 9 BLR 1-65 (19186)(en banc). Evidence which is in equipoise is insufficient to sustain the Claimant's burden of proof. *Director, OWCP v. Greenwich Collieries, et al.*, 114 S. Ct. 2251 (1994); *aff'g sub nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730 (3d Cir. 1993). Failure to establish any one of these elements precludes entitlement to benefits.

Pneumoconiosis

Section 718.202 provides four means of establishing the existence of pneumoconiosis. Pursuant to § 718.202(a)(1) through § 718.202(a)(4), Claimant can establish the presence of pneumoconiosis by means of 1) chest X-rays; 2) biopsy or autopsy evidence; 3) the regulatory presumptions found at §§ 718.304, 718.305, and 718.306, if found to be applicable; and 4) a reasoned medical opinion based on objective evidence such as pulmonary function studies, arterial blood gas tests, physical examinations, and medical and work histories.

Under the provisions of §718.202(a)(1), chest x-rays that have been taken and evaluated in accordance with the requirements of §718.102 may form the basis for a finding of the existence of pneumoconiosis if classified in Category 1, 2, 3, A, B, or C under an internationally-adopted classification system. An x-ray classified as Category 0, including subcategories 1/-, 0/0 and 0/1 does not constitute evidence of pneumoconiosis. Under §718.202(a)(1), when two or more x-ray reports are in conflict, consideration must be given to the radiological qualifications of the physicians interpreting the x-rays. *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 536 (4th Cir. 1998).The following chest x-ray readings are in the record:

Ex. No.	Date of x-ray	Physician/Qualifications[2]	Impression
DX 14	3/7/77	Stallard B	0

[2] The symbol "B" denotes a physician who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. §37.51 (1982).

The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. §727.206(b)(2)(iii).

Ex. No.	Date of x-ray	Physician/Qualifications[2]	Impression
CX 1	7/18/00	Vaezy	p/q 1/0
DX 13	4/3/01	Broudy B	no pneumoconiosis
DX 18	4/3/01	Branscomb B	no pneumoconiosis
DX 12	5/16/01	Sargent B BCR	Quality 1
DX 12	5/16/01	Hussain	p/s 2/2 A
DX 17	5/16/01	Wheeler B BCR	no pneumoconiosis
DX 31	5/16/01	Hussain	p/s 1/0
EX 1	5/16/01	Scott B BCR	no pneumoconiosis
CX 2	7/24/02	Baker B	p/t 1/0
EX 12	7/24/02	Wheeler B BCR	no pneumoconiosis
EX 2	1/16/03	Dahhan B	negative

Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co.*, 7 BLR. 1-128, 1-131 (1984).

Dr. Hussain originally read the May 16, 2001 chest x-ray as positive for complicated pneumoconiosis. When provided the x-ray for re-reading, along with the medical report of Dr. Branscomb, Dr. Hussain changed his reading to indicate that the x-ray was positive for simple pneumoconiosis only. (DX 31).

The deposition testimony of Dr. Wheeler was taken on March 3, 2003. (EX 3). Dr. Wheeler testified regarding his readings of the x-rays as noted above. Dr. Wheeler noted a calcified granuloma in the chest x-ray of May 16, 2001, but did not find evidence of coal worker's pneumoconiosis.

[2] The symbol "B" denotes a physician who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. §37.51 (1982).

The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *20 C.F.R. §727.206(b)(2)(iii).*

All of the readings by B-readers who are also board-certified radiologists, the most highly qualified physicians, are negative for pneumoconiosis. The preponderance of the x-ray readings by all physicians of record is also negative for the disease. Based upon the vast preponderance of negative readings and, in particular, the negative readings by the more highly qualified physicians of record, I find that the Claimant has not established the presence of pneumoconiosis by means of the x-ray evidence pursuant to §718.202(a)(1).

Section 718.202(a)(2) provides that an autopsy or biopsy conducted and reported in compliance with Section 718.106 may be the basis for a finding of the existence of pneumoconiosis. There is no autopsy evidence of record, nor is there any biopsy evidence of pneumoconiosis. Accordingly, the Claimant cannot prove the presence of the disease under subsection (a)(2).

Pursuant to § 718.202(a)(3), the existence of pneumoconiosis may be established by the presumptions set forth at §718.304, 718.305 and 718.306. The latter two do not apply, as the Claimant filed his claim after January 1, 1982, and this is not a death claim. Section 718.304(a) provides that the existence of complicated pneumoconiosis may be established when diagnosed by a chest x-ray which yields one or more large opacities (greater than 1 centimeter) and would be classified in Category A, B, or C. X-ray evidence is not the exclusive means of establishing complicated pneumoconiosis under §718.304. Its existence may also be established under §718.304 (b) by biopsy or autopsy or under §718.304 (c), by an equivalent diagnostic result reached by other means. The Benefits Review Board has held that the Administrative Law Judge must first determine whether the relevant evidence in each category tends to establish the existence of complicated pneumoconiosis and then must weigh together the evidence at each subsection before determining whether invocation of the irrebuttable presumption under §718.304 has been established. *Melnick v. Consolidated Coal Co.,* 16 BLR. 1-31, 1-33 (1991) (*en banc*).

In the instant case, the only finding of complicated pneumoconiosis was rendered by Dr. Hussain in his reading of the May 16, 2001 chest film, which he later retracted. No other physician found complicated pneumoconiosis to be present, including the dually qualified physicians of record who reviewed chest x-rays and CT scans. Nor is there any biopsy evidence or other medical record establishing the presence of complicated pneumoconiosis. Therefore, I do not find that the evidence is sufficient to establish the existence of complicated pneumoconiosis pursuant to 20 C.F.R. §718.304.

Under §718.202(a)(4), the Claimant may also establish the existence of pneumoconiosis, notwithstanding negative x-rays, by well reasoned, documented medical reports. The regulation provides that any such finding by a physician must be based on objective medical evidence, such as blood gas studies, pulmonary function studies, physical performance tests, physical examinations, and medical and work histories. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 BLR. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 BLR. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6

BLR. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields,* above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 BLR. 1-149, 1-155 (1989) *(en banc).*

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 BLR. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWCP*, 14 BLR. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration in . . . weighing . . . the medical evidence . . ." *Tedesco v. Director, OWCP*, 18 BLR. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." *20 CFR § 718.104(d)* .The medical opinion evidence is set forth below.

Dr. Glen Baker

The medical records of Dr. Glen Baker, the Claimant's treating physician, are included in the record. (CX 1, Tr. 29). However, the handwritten pages of these records are, for the most part, illegible and of little probative value. The records also include treatment notes of. Abdi Vaezy, who In a note dated July 18, 2000, diagnosed severe obstructive lung disease, and stated that the Claimant should not work in a dusty workplace such as a coal mine. In a letter of the same date, written to Dr. Premji, Dr. Vaezy indicated the Claimant had the following conditions: (1) COPD with asthmatic component; (2) coal worker's pneumoconiosis, stage 1/0; and obesity. Dr. Vaezy noted that Claimant's chest x-ray showed small opacities, p/q 1/0. He reported that the Claimant had a smoking habit of two packs of cigarettes per day for about forty years.In Progress Notes from August and October of 2000, COPD is noted, and. CWP is noted in a Progress Note from August 1, 2000. On August 1, 2000, Dr. Vaezy noted that the Claimant had a moderate obstructive ventilatory impairment with significant improvement since July 18, 2000. A *Multi-System Examination Form,* dated May 8, 2001, listed an Assessment of COPD/OB.

The Claimant underwent a bronchoscopy and esophagoscopy in November of 2000. (CX 1). Biopsy results revealed a reactive squamous epithelium. Dr. Tiu read a CT scan of the chest dated November 1, 2000. (CX 1). He found the presence of a subcarinal soft tissue mass , which showed no change from the prior exam of September of 2000. The mass found in the scan was felt to be located posterior and extrinsic to the esophagus. On November 15, 2000, Dr. Sibu Saha read a chest x-ray and CT scan, listing a Final Impression which included (1) recurrent respiratory failure; (2) bronchial asthma; (3) probable inthrathoracic lesion causing extrinsic esophageal compression; (4) dyphagia, rule out esophageal lesion; (5) obesity; and (6) tobacco abuse. (CX 1). In a letter to Dr. Vaezy, dated November 15, 2000, he gave a clinical assessment

in which he diagnosed: (1) recurrent respiratory infection; (2) bronchial asthma; (3) probable intrathoracic lesion causing extrinsic esophageal compression; (4) dysphagia, rule out esophageal lesion; (5) obesity; and (6) tobacco abuse.

A CT scan conducted on December 26, 2000 was read by Dr. Nelson Rice as indicative of a lobular mass just posterior to the esophagus at the level of the left atrium. (CX 1). The favored diagnosis was granuloma. A large hematoma was also noted.

On May 11, 2001, Dr. Baker wrote Dr. Premji, regarding his examination of the Claimant for his pulmonary condition. Dr. Baker stated that the x-ray showed borderline pneumoconiosis as either 0/1 or 1/0. He further indicated that he had discussed with the Claimant the main cause of his symptoms at the present time were partly related to his smoking habits. Dr. Baker strongly encouraged the Claimant to discontinue his smoking habit. Dr. Saha saw the Claimant on January 16, 2002, for his esophageal problem. (CX 1). He noted that the Claimant was "stable."

Dr. Baker examined the Claimant on July 24, 2002. (CX 2). He recorded a cigarette smoking history of one pack per day for thirty years, the Claimant having quit smoking eleven months previously. Based upon his examination, a positive chest x-ray, pulmonary function studies which revealed moderate obstructive defect, and blood gases which demonstrated a moderated decrease in PO2, Dr. Baker opined that the Claimant had a Class III impairment. His diagnosis included (1) coal worker's pneumoconiosis, category 1/0, based on abnormal chest x-ray and significant history of dust exposure; (2) moderate atrial hypoxemia; (3) chronic obstructive airway disease with moderate obstructive defect, based on pulmonary function testing; and (4) chronic bronchitis, by history. Dr. Baker attributed the Claimant's disease to coal dust exposure. He was of the opinion that he had a pulmonary impairment related, at least in part, to coal dust exposure, noting that the Claimant had a long history of smoking as well as a long history of coal dust exposure.

Dr. Baker also concluded that Claimant had a second impairment with the presence of pneumoconiosis, and that the Claimant was disabled from coal mine work. He reached his conclusion, relying upon the *Guides to the Evaluation of Permanent* Impairment, Fifth Edition, which states that persons who develop pneumoconiosis should limit further exposure to the offending agent. He indicated that this standard "would imply" that the Claimant was "100% occupationally disabled for work in the coal mining industry." Dr. Baker is board-certified in internal medicine and in pulmonary disease,

Dr. Bruce Broudy

Dr. Bruce Broudy, who is board-certified in internal medicine and pulmonary disease, examined the Claimant on April 3, 2001. (DX 13, EX 7). A cigarette smoking history of one pack per day beginning as a teenager and continuing to present was recorded, as was the fact that the Claimant had quit smoking a few times. Based upon his examination, the Claimant's occupational, medical, and smoking histories, a negative chest x-ray, a pulmonary function study which showed a restrictive defect, and normal blood gas testing, Dr. Broudy diagnosed (1) asthmatic bronchitis; (2) massive obesity; and (3) hypertension. Dr. Broudy opined that the Claimant did not have coal worker's pneumoconiosis. He found the respiratory impairment

present to be due to massive obesity and asthmatic bronchitis. It was his opinion that the Claimant was disabled from a respiratory standpoint, however the etiology of same was not the Claimant's occupation as a coal miner.

Dr. I. Hussain

Dr. I. Hussain examined the Claimant on May 16, 2001. (DX 12). Dr. Hussain recorded a smoking history of thirty years at the rate of 20 cigarettes per day, the Claimant being a current smoker. Based upon his examination, a positive chest x-ray, pulmonary function studies which revealded a mild obstructive defect, and normal blood gas testing, Dr. Hussain diagnosed pneumoconiosis due to dust exposure. He found the Claimant to be suffering from a moderate impairment. Dr. Hussain indicated that the basis for his diagnosis of pneumoconiosis was the chest x-ray findings. He opined that the Claimant was disabled from coal mine work. Dr. Hussain is board-certified in internal medicine and pulmonary disease.

Dr. Ben V. Branscomb

Ben V. Branscomb submitted a report dated October 11, 2001, after reviewing the medical evidence of record. (DX 16). Based upon his review, Dr. Branscomb concluded that the Claimant was probably disabled from his previous coal mine work by a level of obesity which interfered with ambulation, ladder climbing and other necessary activities. He noted that the blood gases were normal for a person with morbid obesity. It was his opinion that the Claimant probably had asthma or asthmatic bronchitis, which would be the result of congenital factors plus possible aggravation by smoking. Dr. Branscomb found no reasonable basis for concluding that coal mine dust exposure would have any continuing adverse effect on the asthma that was present. Dr. Branscomb found no coal worker's pneumoconiosis to be present.

The deposition testimony of Dr. Branscomb was taken on November 14, 2001. (DX 18). At that time, Dr. Branscomb reiterated his opinion as noted above. He also stated his disagreement with the finding of Dr. Hussain, that the chest x-ray was positive for complicated pneumoconiosis. Dr. Branscomb submitted a supplemental report dated July 31, 2003, after reviewing additional medical evidence. (EX 4). That review caused him to point out the documentation of the strongly positive family history for asthma. While he found the pulmonary function studies conducted by Drs. Dahhan and Baker to be questionably invalid, those studies did provide sufficient confirmation for him to conclude that there was moderate obstructive airways disease at the time of the tests. He found the Claimant's morbid obesity to be at least as disabling as the asthma and COPD. He concluded that with total cessation of smoking and consistent therapy, the Claimant would probably achieve marked improvement in pulmonary function. Dr. Branscomb is board-certified in internal medicine. See also EX 5, deposition transcript of Dr. Branscomb dated August 12, 2003.

Dr. A. Dahhan

Dr. A. Dahhan examined Claimant on January 16, 2003, reviewed the medical records and was deposed on July 15, 2003. (EX 2, EX 6). Dr. Dahhan is board-certified in internal medicine and pulmonary disease. He recorded a cigarette smoking history of a pack per day

starting at the age of fifteen years, Claimant having reduced the amount to half a pack per day two years ago. Based upon his examination, Claimant's occupational, medical and smoking histories, a negative chest x-ray, blood gas study, and a pulmonary function study which indicated severe obstructive ventilatory defect with no evidence of restrictive ventilatory abnormality, Dr. Dahhan found insufficient objective findings to justify a diagnosis of coal worker's pneumoconiosis. He observed that the Claimant's carboxyhemoglobin level was equivalent to that of an individual smoking a pack of cigarettes per day.

Dr. Dahhan diagnosed chronic obstructive lung disease due to Claimant's lengthy smoking history, and the contributing factor of obesity. He was of the opinion that, from a respiratory standpoint, the Claimant did not retain the physiological capacity to continue his previous coal mining work. He opined that Claimant's pulmonary disability was not caused by, related to, contributed to, or aggravated by the inhalation of coal dust or coal worker's pneumoconiosis. During his deposition, Dr. A. Dahhan stated the Claimant suffered from chronic bronchitis and emphysema under the umbrella of chronic obstructive lung disease, which was in no way attributable to exposure to coal dust.

Upon reviewing the medical opinions of record, I find the Claimant has failed to satisfy his burden of proving the existence of pneumoconiosis under subsection (a)(4). While legal pneumoconiosis is a broader concept than clinical pneumoconiosis, *Gulf & Western Industries v. Ling*, 176 F.3d 226 (4th Cir. 1999), and thus may exist under circumstances in which a physician is unable to detect clinical pneumoconiosis, *Barber v. Director, OWCP*, 43 F.3d 899 (4th Cir. 1995), there is no well-reasoned, well-documented medical report herein which reaches the conclusion that Claimant is suffering from legal or clinical pneumoconiosis.

Dr. Hussain diagnosed pneumoconiosis based upon his own positive x-ray reading. However, his opinion is not accorded great weight, since the two highly qualified physicians who were B-readers and board-certified radiologists found the x-ray relied upon by Dr. Hussein to be negative, and I have found the preponderance of the x-ray readings to be negative for the disease. His opinion is also given less weight because he does not adequately address the role, if any, other significant factors played in the Claimant's pulmonary condition, including his obesity and his history of tobacco abuse.

Dr. Vaezy found obstructive lung disease, but he failed to state the etiology of this condition. His treatment records do not definitively diagnose coal worker's pneumoconiosis, nor does he render a well-reasoned medical opinion in support of his diagnosis. Finally, his diagnosis of pneumoconiosis by chest x-ray reading is not accorded great weight, as it is contrary to the opinions of more highly qualified physicians who found the disease to be absent., and he does not state reasons for his diagnosis based on other objective medical evidence.

Another treating physician, Dr. Saha, makes no mention of the disease. The physicians who read the CT scans of the chest also fail to diagnose the disease. Dr. Baker diagnoses pneumoconiosis by chest x-ray, when as noted, the preponderance of the readings by the most highly qualified physicians of record, was negative for the disease. He also diagnoses a pulmonary impairment which he states is due at least in part to the Claimant's exposure to coal dust, however, Dr. Baker fails to adequately discuss this finding or the supporting documentation

for it. Thus, Dr. Baker fails to explain how he is able to determine that the impairment suffered is due to coal dust exposure, as opposed to tobacco abuse, and makes no mention of the effect the Claimant's morbid obesity might have on his pulmonary capacity.

By contrast, Drs. Dahhan, Broudy and Branscomb find the Claimant does not suffer from pneumoconiosis. They fully discuss all factors in the Claimant's pulmonary impairment, including his obesity, history of tobacco abuse and asthmatic bronchitis. Their opinions are well-supported by the evidence of record, and their reports provide persuasive analyses of the objective laboratory data.

In sum, after weighing all of the medical opinions of record, I accord greater probative weight to the opinions of Drs. Broudy, Branscomb and Dahhan. All three possess excellent credentials, Drs. Broudy and Dahhan being specialists in the field of pulmonary disease. While these same qualifications are held by Drs. Baker and Hussain, for the reasons set forth above, I accord their opinions lesser weight.

Also of significance is the fact that Drs. Dahhan, Broudy and Branscomb had the opportunity to examine the Claimant as well as to review other medical evidence in the record, providing a broader basis for their opinions. I find their reasoning and explanation in support of their conclusions more complete and thorough than that provided by Drs. Baker and Hussain. Thus, Drs. Broudy, Dahhan and Branscomb were better able to explain how all of the evidence they developed and/or reviewed supported their conclusions. I find that their credible and well reasoned medical opinions are convincing for purposes of establishing that the Claimant does not have pneumoconiosis or any other respiratory or pulmonary impairment arising out of coal mine work. This evidence outweighs the contrary conclusion provided by Drs. Baker and Hussain, as well as the medical treatment records which have been submitted in this matter. I conclude, therefore, that the weight of the medical opinions of record fails to establish that the Claimant has pneumoconiosis as the Act requires for entitlement to benefits. Therefore, upon consideration of the medical opinion evidence of record, I find that the existence of pneumoconiosis has not been established pursuant to §718.202(a)(4).

Total Disability

Even assuming, arguendo, that the Claimant could prove that he has pneumoconiosis, he would not prevail on his claim because he cannot prove that he is totally disabled by pneumoconiosis.

Benefits under the Act are provided for miners who are totally disabled due to pneumoconiosis. A miner shall be considered totally disabled if the irrebuttable presumption of §718.304 applies. The irrebuttable presumption set forth at Section §718.304 provides that if a miner is suffering from a chronic dust disease of the lung which yields one or more large opacities on chest x-ray which would be classified as Category A, B, or C or one or more massive lesions on biopsy, then such miner shall be presumed to be totally disabled due to pneumoconiosis. *20 C.F.R. §718.204(b), 20 C.F.R. §718.304.* As discussed above, however, I have found the evidence insufficient to establish the existence of complicated pneumoconiosis. Thus, total disability is not established by the irrebuttable presumption of §718.304 as provided

in Section §718.204(b).

Total disability may also be established, if pneumoconiosis prevents a miner form performing his usual coal mine work or comparable and gainful employment. *20 C.F.R. §718.204(b)*. In the absence of contrary probative evidence, evidence which meets one of the standards of either §7718.204(b)(2)(i)-(iv) may establish a miner's total disability. I note at the outset that subsection (b)(2)(iii) is not applicable because there is no evidence that the Claimant suffers from cor pulmonale with right-sided congestive heart failure.

Pulmonary function studies can establish total disability where the values are equal to or less than those listed in Table B1 in Appendix B to Part 718. Assessments of these results is dependent on the Claimant's height which was recorded as 67 and 68 inches. Considering this discrepancy, I find the Claimant's height to be 67.5 inches for the purposes of evaluating the pulmonary function studies. *Protopappas v. Director, OWCP*, 6 BLR 1-221 (1983). The following pulmonary function studies have been submitted since the prior denial:

Exhibit No.	Date	Physician	Age/Height	FEV1	FVC	MVV
CX 1	8/29/00	Vaezy	54/67"	1.61	2.50	
CX 1	10/30/00	Vaezy	55/67"	1.65	2.21	
DX 13	4/3/01	Broudy	55/67"	1.64	2.37	47
		Post-bronchodilator		1.74	2.48	50
DX 12	5/16/01	Hussain	55/68"	1.69	2.40	55
DX 15	8/17/01	Hussain	56/68"	1.38	2.28	39
		post-bronchodilator		1.26	2.10	
CX 1	10/2/01	Baker	56/67"	1.33	1.98	
CX 1	2/19/02	Baker	56/67"	1.37	2.13	
CX 2	7/24/02	Baker	56/ 67"	1.48	2.36	
EX 2	1/16/03	Dahhan	57/67"	1.38	2.12	47
		post-bronchodilator		1.42	2.23	50

Dr. Broudy listed the Claimant's effort as fair in the study he conducted on April 3, 2001. (DX 13). Dr. Branscomb found that study to be invalid. (DX 16). It was his opinion that the study did not provide maximum effort or measure true pulmonary function. Dr. Branscomb also found the May 16, 2001 pulmonary function study to be invalid. (DX 16).

Dr. Burki found the two studies conducted by D. Hussain to be invalid. (DX 12, 15). He found the May 16, 2001 study to be invalid due to less than optimal effort, cooperation and comprehension, noting that the flow volume loops indicated inadequate inspiration. He found the August 17, 2001 study to have been improperly performed, with less than optimal effort, cooperation and comprehension. (DX 15). Dr. Burki noted that the curves shapes indicated suboptimal effort and the low volume loops were incomplete. He also found the study conducted by Dr. Broudy on April 3, 2001 to be invalid due to the fact that the equipment did not meet specifications. (EX 9). In particular, he found that the paper speed was too slow. Dr. Burki is board-certified in internal medicine and pulmonary diseases.

Dr. Broudy, who is board-certified in internal medicine and pulmonary disease, found the studies conducted on August 17, 2001 to be invalid due to suboptimal effort. (EX 10). He found that the May 16, 2001 study showed better results and the trials were repeatable, "suggesting that this may have been a valid study."

Dr. Branscomb found the studies conducted on August 29, 2000, October 30, 2000, October 2, 2001 and February 19, 2002 study to be invalid due to a lack of tracings. (EX 4). He was also not convinced that the study conducted by Dr. Dahhan was valid, given the cough in the middle of expiration and a good deal of variation between consecutive efforts. (EX 4). He concluded that the test did not achieve the requirements for validity.

In his deposition testimony, Dr. Branscomb stated that he had reviewed the pulmonary function study of August 17, 2001, and found that it was invalid. (DX 18). In a subsequent deposition, Dr. Branscomb testified that the July 24, 2002 study was invalid as the study was done in the presence of wheezing.

While every pulmonary function study conducted produced values indicative of total disability, every study was also found to be invalid. The studies, dated August 29, 2000, October 30, 2000, October 2, 2001 and February 19, 2002., are not accompanied by tracings, and obviously do not conform to the quality standards of the regulations. Therefore, they will not be considered herein, Additionally, the remaining studies were found to be invalid by various physicians. I find that these studies are not reliable indicators of the Claimant's pulmonary capacity and further find that they are insufficient to meet the Claimant's burden of establishing total disability pursuant to 20 C.F.R. §718.204(b)(2)(i).

Under the provisions of subsection 718.204(b)(2)(ii), a claimant can establish total disability if arterial blood gas tests show values conforming to Appendix C to Part 718.The following blood gas studies have been submitted.

Ex. No.	Date	Physician	PC02	PO2
CX 1	7/18/00	Vaezy	47	57
DX 13	4/3/01	Broudy	37.8	87.2

Ex. No.	Date	Physician	PC02	PO2
DX 12	5/16/01	Hussain	39.0	63
		after exercise	35.2	68
CX 2	7/24/02	Baker	42	63
EX 2	1/16/03	Dahhan	40.5	62.1
		after exercise	38.4	75.7

None of the blood gas studies produced values indicative of total disability. Accordingly, I find that total disability has not been established pursuant to 20 C.F.R. §718.204(b)(2)(ii).

The final means of establishing total disability is pursuant to Section 718.204(b)(2)(iv), which provides that total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a respiratory or pulmonary impairment prevents the miner from engaging in his usual coal mine work or comparable and gainful work.

In the instant case, the treating physicians, apart from Dr. Baker, do not render an opinion regarding disability. Dr. Baker found a Class II impairment, concluding that Claimant has a pulmonary impairment, and should limit his exposure to the offending agent. In his view, the fact that the Guides to the Evaluation of Permanent Impairment indicated that a person who has pneumoconiosis should limit his exposure to coal dust, would in Claimant's case support a total disability assessment. In assessing total disability under § 718.204(c)(4), the fact-finder, is required to compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, Case No. 99-3469 (6th Cir. Sept. 7, 2000) (a finding of total disability may be made by a physician who compares the exertional requirements of the miner's usual coal mine employment against his physical limitations); *Schetroma v. Director, OWCP*, 18 BLR. 1-19 (1993) A physician's recommendation that the miner remove himself from coal mine dust exposure does not constitute a well reasoned basis for a finding of total disability. Thus, Dr. Baker's opinion, to the extent that it is based on such a rationale, is insufficient to support a finding of total disability. Further, I am unable to discern from Dr. Baker's opinion and the stated rationale for that opinion whether he took into consideration the physical requirements of the Claimant's coal mine job, and made a determination based on objective medical evidence of whether the miner's pulmonary condition precluded him from performing the duties of that job. As such, I find Dr. Baker's disability assessment to be less than credible.

Dr. Branscomb finds the Claimant to be suffering from asthma or asthmatic bronchitis, finding a moderate obstructive airways disease to be present. Dr. Dahhan found the Claimant to be suffering from a chronic obstructive lung disease, concluding that the Claimant did not retain the physiological capacity to perform his previous coal mine work. Dr. Hussain finds total disability, finding a moderate pulmonary impairment. Dr. Broudy finds a disabling respiratory impairment as well. Based upon the medical opinions of Drs. Dahhan and Broudy in particular, supported as they are by the opinions of Drs. Branscomb and Hussain, I find that the Claimant

has established total disability by the medical opinion reports under the provisions of §718.204(b)(2)(iv).

Inasmuch as the Claimant has established total disability pursuant to 20 C.F.R. §718.204(b)(2)(iv), the contrary probative evidence must be weighed in order to determine whether total disability has been established. *20 C.F.R. §718.204(b)(2)*. When weighing the contrary probative medical evidence of record in this case, I find that that evidence, including the non-qualifying blood gas studies and invalidated pulmonary function studies, does not outweigh the medical opinion evidence of record. Therefore, I find that the totality of the medical evidence establishes total disability pursuant to 20 C.F.R. §718.204(b)(2).

The Claimant must also establish that his total disability is due to pneumoconiosis. Total disability due to pneumoconiosis requires that pneumoconiosis as defined in §718.201, be a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Substantially contributing cause is defined as having a "material adverse effect on the miner's respiratory or pulmonary condition" or as "materially worsen[ing] a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment."*20 C.F.R. §718.204(c)(1)(i) and (ii*). Absent a showing of cor pulmonale or that one of the presumptions of §718.305 are satisfied, it is not enough that a miner suffer from a disabling pulmonary or respiratory condition to establish that this condition was due to pneumoconiosis. *See 20 C.F.R.. §718.204(c)(2)*. Total disability due to pneumoconiosis must be demonstrated by documented and reasoned medical reports. *Id.*

The evidence fails to establish that the Claimant is totally disabled due to pneumoconiosis as required by §718.204(c)(1). No evidence of cor pulmonale or evidence satisfying the presumptions of §718.305 has been offered. Drs. Branscomb, Dahhan and Broudy, all of whom find a respiratory condition to be present attribute it to causes other than coal mine dust inhalation. While Drs. Hussain and Baker appear to attribute it the pulmonary impairment to pneumoconiosis, for the reasons stated above, I do not find their opinions to be persuasive. This is particularly the case with regard to the etiology of the pulmonary impairment, inasmuch as they both rely on positive chest x-ray readings to diagnose the disease, and fail to adequately discuss the Claimant's other significant conditions. Thus, neither physician fully and adequately addresses the Claimant's obesity, tobacco abuse or family history of asthma. Based on the well-reasoned and well-documented medical opinions of Drs. Dahhan, Broudy and Branscomb, I find that total disability due to pneumoconiosis has not been established.

Entitlement

Since Claimant has not established the existence of pneumoconiosis arising out of coal mine employment or total disability due thereto, his claim must be denied.

Attorney's Fees:

The award of attorney's fees under the Act is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for services rendered in pursuit of benefits.

ORDER

It is therefore ORDERED that the claim of Edward Merrill for benefits under the Act is hereby DENIED.

A

MOLLIE W. NEAL
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a Notice of Appeal must also be served upon Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Francis Perkins Bldg., Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.